Perinatal Mental Health and Substance Use Disorders: Their Impact and What We Can Do About It
Objective 1: To provide an overview of epidemiology related to perinatal mental health conditions, and effects on maternal and infant health, and maternal mortality
Objective 2: To describe current professional recommendations, policies, and expectations, regarding integration of obstetric and behavioral health care
Objective 3: Outline approaches to sealing gaps in care by building front line provider capacity to address perinatal mental health, substance use disorders and intimate partner violence.
Speakers

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Maternal Mortality:
Obstetric Providers need to address Mental Health

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Medical Director, Lifeline4Moms
Vice Chair and Research Division Director, Dept. of Obstetrics & Gynecology
University of Massachusetts Medical School/UMass Memorial Health Care
## Disclosure: Tiffany Moore Simas, MD, MPH, MEd

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Mental Health Conditions (PMAD & SUD) are the most common complications of pregnancy

1 in 5 women around the world will suffer from a maternal mental health complication

#MaternalMHMatters

http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression
Substance Use Disorder in pregnancy often co-occur with mental health conditions and are common.

- 5% illicit substances*
- 10% drink alcohol*
- 15% use tobacco*

More common than:
- Cystic fibrosis
- GDM
- Preeclampsia

* SAMHSA (2013) – self-reported, civilian, non-incarcerated
Maternal mental health affects mom, child, and family

Preterm delivery
Low birth weight
NICU admissions

Cognitive delays
Motor & Growth issues
Behavioral problems
Mental health disorders

Less engagement in medical care
Smoking & substance use

Lactation challenges
Bonding issues
Adverse partner relationships
The vast majority of perinatal mental health conditions are unrecognized and untreated. 

Mental Health Conditions are a Leading Underlying Cause of Pregnancy-Related Deaths

Mental Health Conditions:

Any deaths where the MMRC identified mental health conditions, depression, or other psychiatric conditions as an underlying cause of death; including suicide (69%), and unintentional overdose (19%) or injury of unknown intent where substance use disorder or mental health conditions were documented (22%).

Most deaths occurred during the postpartum period

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<th>Percentage</th>
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<td>19%</td>
<td>of deaths occurred during pregnancy</td>
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<tr>
<td>14%</td>
<td>of deaths occurred within 42 days of end of pregnancy</td>
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<tr>
<td>68%</td>
<td>of deaths occurred 43-365 days postpartum</td>
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Mental health conditions and infection were the leading causes among preventable deaths.
100% of pregnancy-related mental health deaths were determined to be preventable
Contributors & recommendations: themes

**Lack of Care Coordination**
- Improve follow-up care for women with mental health diagnoses
- Improve access to records between medical providers
- Expand case management for patients with mental health diagnoses
- Establish/expand home visiting services for new moms

**Lack of Access to Mental Health Services**
- Increase mental health & substance use screening at OB/GYN intake
- Provider education to increase knowledge of mental health specialist availability for referral
- Expand peer support programs for substance use disorder
- Establish a mental health hotline
- Improve mental health and substance use services in jails
The health care system needs to change to address perinatal mental health & substance use disorders
Women need to be screened for Perinatal Mood and Anxiety Disorders (PMADs)

2015, 2018

Depression & Anxiety
At least once during the perinatal period

2016

Depression
At least once during pregnancy and again pp

2016-2017

Depression & Anxiety (Bipolar disorder)
Twice in pregnancy and again pp

ACOG CO 630 May 2015 → ACOG CO 757 Nov 2018; USPSTF JAMA 2016; Kendig et al Obstet Gynecol 2017
Women need to be screened for Substance Use Disorders in Pregnancy

• Comprehensive part of prenatal Care
  • 1st prenatal Visit

• Universal
  • Diverse population

• Validated tool
  • Self-report underestimates frequency and severity
  • Testing with risks of false positives (esp immunoassays)

• Partnership with pregnant woman
Patent Safety Bundle

2016

Maternal Mental Health

2017

Obstetric Care for Women

with Opioid Use Disorder

- Readiness
  Every Clinical Care Setting

- Recognition & Prevention
  Every Woman

- Response
  Every Case

- Reporting/Systems Learning
  Every Clinical Care Setting

Council on Patient Safety in Women’s Health Care

Safe health care for every woman
The perinatal period is ideal for the detection, assessment and treatment of PMAD & SUD

Regular opportunities to screen and engage women in treatment

Obstetric providers have a pivotal role
- Patient acceptability
- Decrease stigma
- 80 PCP:20 Psych
Many obstetric providers are inadequately prepared and resourced to address PMAD & SUD

- Not always part of professional identity
- Lack of guidance
- Lack of training
- Lack of resources and referrals
- Inadequate psychiatric referral network
It is difficult for pregnant and postpartum women to access treatment
We need multi-level interventions that address patient, provider systems and barriers.
National Initiatives for Building Front-line Provider Capacity to Address Perinatal Mental Health and Substance Use Disorders

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Executive Director, Lifeline4Moms
Director, Division of Women’s Mental Health in the Dept. of Psychiatry
University of Massachusetts Medical School/UMass Memorial Health Care
Disclosure: **Nancy Byatt, DO, MS, MBA**

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Building front line provider capacity to provide mental health care can provide a solution
How can you or you state or health system help address this and what resources are available?
Training

Consultation & Resources

Implementation into practice workflow
Education occurs through trainings, toolkits, and website resources

MCPAP for Moms promotes maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage mental health and substance use concerns.

Provider Resources

- Trainings and toolkits for providers and their staff on evidence-based guidelines for depression screening, triage and referral, risks and benefits of medication, and discussion of screening results and treatment options.
- Real-time psychiatric consultation and care coordination for providers serving pregnant and postpartum women including obstetricians, pediatricians, adult primary care physicians, and psychiatrists.
- Linkages with community-based resources including mental health care, support groups and other resources to support the wellness and mental health of pregnant and postpartum women.

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT 855-666-6272

Antidepressant Treatment Algorithm (use in conjunction with Depression Screening Algorithm for Obstetric Providers)

1. Is patient currently taking an antidepressant?
   - Yes: If medication has helped and patient is on a low dose, increase dose of current medication (see table below).
   - No: If patient is on therapeutic dose for 4-8 weeks that has not helped, consider changing medication. If questions contact MCPAP for Moms for consultation.

2. Does patient have a history of taking an antidepressant that has helped?
   - Yes: Prescribe antidepressant that helped patient in the past (see table below).
   - No: Use sertraline, fluoxetine or citalopram (see table below).

To minimize side effects, the half recommended dose is used initially for 2 days, then increase in small increments as tolerated.

First line treatment (SSRIs)

<table>
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<tr>
<th>Sertraline (Zoloft)</th>
<th>Fluoxetine (Prozac)</th>
<th>Citalopram (Celexa)</th>
<th>Escitalopram (Lexapro)</th>
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<td>50-200 mg increase in 50 mg increments</td>
<td>20-60 mg increase in 10 mg increments</td>
<td>20-40 mg increase in 10 mg increments</td>
<td>10-20 mg increase in 10 mg increments</td>
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Second line treatment

<table>
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<th>Paroxetine (Paxil)</th>
<th>Venlafaxine (Effexor)</th>
<th>Mirtazapine (Remeron)</th>
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<td>75-100 mg increase in 25 mg increments</td>
<td>15-45 mg increase in 15 mg increments</td>
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<tr>
<td>Fluoxetine (Prozac)</td>
<td>Duloxetine (Cymbalta)</td>
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<tr>
<td>30-200 mg increase in 50 mg increments</td>
<td>20-60 mg increase in 10 mg increments</td>
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Reevaluate depression treatment in 2-4 weeks via EPDS & clinical assessment

- If no/minimum clinical improvements after 4-8 weeks:
  1. If patient has no or minimal side effects, increase dose.
  2. If patient has side effects, switch to a different med.
- If you have any questions or need consultation, contact MCPAP for Moms at 855-Mom-MC (855-666-6272)

If clinical improvement and no/minimal side effects, continue as above. Reevaluate every month and at postpartum visit. Refer back to patient’s provider and/or clinical support staff for psychiatric care once OB care is complete. Contact MCPAP for Moms if it is difficult to coordinate ongoing psychiatric care. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.
Toolkit for addressing perinatal mental health conditions

www.lifeline4moms.org
MCPAP for Moms promotes maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage mental health and substance use concerns.
Toolkit for addressing substance use disorders in pregnancy and postpartum

www.mcpapformmoms.org

Screening and Brief Intervention for Substance Use in Pregnancy

All women should be screened for substance use at the first prenatal visit using a screening tool: e.g., the Modified NIDA Quick Screen (Modified NIDA) (see SUD2).

If positive screen on Modified NIDA, had aberrant urine test, or clinical suspicion (see SUD2), women is at risk

Brief Assessment
1. “What substances have you been using in the past 6 months? During this pregnancy?”
2. “How much of each substance have you been using at a time?”
3. “How frequently are you using them?”
4. “How does this affect your life (job, home life, self-care, health, emotions)?”
5. “Are you being treated for an SUD? Have you had prior treatment?”

If negative screen, then woman is lower risk

Educate
1. Provide brief education about recommendations to not use alcohol, tobacco, cannabis, illicit opioids, or other drugs
2. Encourage the patient to ask for help in the future, as needed.

Stratify into risk group

High Risk
- Current: Opioid use or binge pattern/day use of any substance(s) or release of any SUD

Moderate Risk
- Current: Low-level use of non-opioid substances, engaged in MAT, or other SUD treatment
- History: High use in past and/or past treatment for SUD

Low Risk
- Current: No use
- History: Low-level use prior to learning of pregnancy

Brief Intervention

High Risk
1. “How ready are you to quit now?” Ask the patient to rate their motivation on a scale from 1-10.
2. “How confident are you that you can stop?” Ask the patient to rate their confidence on a scale from 1-10.
3. “Why did you rate that way?”
4. “How can we increase this score?”

Moderate Risk
1. “How ready are you to quit now?” Ask the patient to rate their motivation on a scale from 1-10.
2. “How confident are you that you can stop?” Ask the patient to rate their confidence on a scale from 1-10.
3. “Why did you rate that way?”
4. “How can we increase this score?”

Low Risk
1. Repeat Modified NIDA and Brief Assessment at least once per trimester
2. Urine testing at least once per trimester
3. Chart MASTPAT at each visit
4. If already in treatment, contact SUD provider
5. Identify who will coordinate Plan of Safe Care (see SUD3)
6. Call MCPAP for Moms with questions

Monitor
1. Monitor and refer to treatment

Is there an active need for a referral to treatment?
Yes
1. Counseling on MAT in pregnancy (see SUD) and non-pharmacological treatment (see SUD)
2. Formulate a monitoring plan including:
   - Repeat Modified NIDA and Brief Assessment at least once per trimester

For all women with any opioid use or on MAT for OUD, discuss:

No
1. Continue to monitor and offer education and support

Create Treatment and Monitoring Plan
1. Refer to or provide medication treatment for opioid/alcohol use (see SUD)
2. Recommend non-pharmacological treatment (see SUD)
3. Formulate a monitoring plan including:
   - Repeat Modified NIDA and Brief Assessment at least once per trimester
Consultation & Resources

Integration into practice workflow

Training
The goal of MCPAP for Moms is to increase the capacity of frontline providers to address perinatal depression.
The goal of MCPAP for Moms is to increase the capacity of frontline providers to address perinatal depression.
Discuss potential management strategies

Recommend a Face to Face Evaluation

Refer to the community
We serve all providers for pregnant and postpartum women

| Obstetric providers/Midwives | Family Medicine/Primary Care providers | SUD providers | Psychiatric providers | Pediatric providers 5% |
Enrolled Practices and Members Served
2013-2014: Depression
2016: Depression, Anxiety
2017: Bipolar Disorder
2018: Substance Use Disorders
2019: Inequities, disparities, TIC, ACEs, SDoH
With MCPAP for Moms, all women across MA have access to treatment for treatment for mental health & substance use disorders.

MCPAP for Moms can serve as a model for other states in the US.

21st Century Cures Act
With MCPAP for Moms, all women across MA have access to treatment for mental health & SUDs.

MCPAP for Moms has served as model for others states in the US.
Partnership Access Line (PAL) For Moms
206-268-2924
Click to learn more!

Dignity Health®

The Meadowlark Initiative
Healthy Prematurity & Secure Families

MC3M
Michigan Child Collaborative Care Program for Moms

The Periscope Project
Perinatal Specialty Consult Psychiatry Program

ncpal
Perinatal Psychiatry

MOPAP For Moms
Massachusetts Child Psychiatry Access Project

MomsPRN
MATERIAL Psychiatry Resource Network

LA&MhPP
Louisiana Mental Health Perinatal Partnership

Florida BH IMPACT
Improving Maternal and Pediatric Access, Care, and Treatment for Behavioral Health
There is global interest in the model
The Lifeline4Moms Network aims to improve maternal & child health through Access Programs
The Network aims to unify programs in the pursuit of a common mission.
The Network also helps aspiring program and brings stakeholders together
Integration into practice work flow

Consultation

Resources

Training
Proactive practice-level interventions are needed to fully integrate mental health care into ob care

- Detect
- Assess
- Treat
- Adequate treatment
- Sustain treatment

**Improved outcomes for moms, babies, and families**

**Symptom improvement**
PRISM leverages existing resources to help practices integrate depression into obstetric care.
Pregnancy: 33%
Postpartum: 40%
Before pregnancy: 27%

Initial Ob visit
26-28 weeks
6 wks post-partum

MDQ
Wisner et al. JAMA Psychiatry. 2013
Care can be stepped up as needed

- EPDS <10
  - Education and monitoring
- EPDS >10; MDQ –
  - Manage in Ob setting with consultation
- EPDS >10; MDQ +
  - Refer to Psychiatrist; Consultation
CDC-funded PRISM Group RCT

Refine PRISM and the large group RCT protocol; Conduct run-in phase (Phase 1)

Conduct Group RCT (Phase 2)
Randomize 10 Ob/Gyn clinics

5 clinics
PRISM
Random selection of perinatal patient study participants from clinic patient roster

5 clinics
MCPAP for Moms alone

Follow patients longitudinally until 12 months postpartum and assess depression and treatment participation

Dissemination to facilitate national uptake (Phase 3)
Truly scalable approaches are still needed
Scalable training and tools are being developed and tested
NIMH-funded Group RCT

- Refine training, toolkit and implementation protocol;
- Conduct run-in phase (Phase 1)

Conduct Group RCT (Phase 2)
- Randomize 25 Ob/Gyn clinics

10 practices 10 practices 5 practices
- e-modules/toolkit, implementation e-modules/training usual care

Chart abstraction and provider surveys

Asses the extent to which the addition and toolkit and lean implementation changes provider practices

Dissemination with ACOG to facilitate national uptake (Phase 3)
Sustainable approaches to addressing perinatal mental health conditions are needed.

- Need scalable implementation approaches
- No financial incentive
- Need sustainable approaches
Integrating mental health care into obstetric care can be transformative for the women we serve.

Led by professional societies and governmental organizations, expectations of obstetric care providers are changing.
QUESTIONS?

Nancy.Byatt@umassmemorial.org

Thank you!